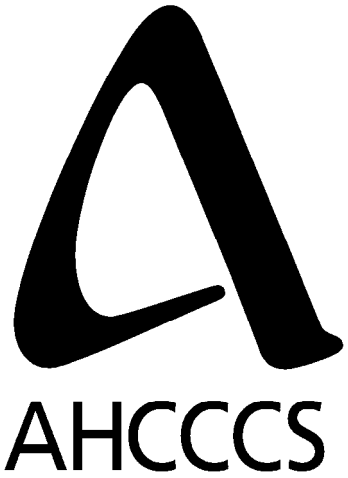

State of Arizona
Arizona Health Care Cost Containment System

Quality Assessment
and
Performance Improvement Strategy

OCTOBER 2005

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INTRODUCTION

In accordance with 42 CFR 438.200 et. seq., the AHCCCS Quality Strategy was established in 2003. It is a coordinated, comprehensive, and pro-active approach to drive quality through creative initiatives, monitoring, assessment, and outcome-based performance improvement. The Quality Strategy is designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of service. It is designed to identify and document issues related to those standards, and encourage improvement through incentives, or where necessary, through corrective actions.

The Quality Strategy document is comprised of five sections.

- Sections I, II, and III describe the AHCCCS Administration's current roadmap for quality over the next five years.

- Section IV describes the breadth and depth of the scope used for quality activities and serves as a bridge for the prior three sections and Section V.

- Section V describes the functions, actions and strategies used by the AHCCCS Administration in meeting the key Federal quality requirements found in the Code of Federal Regulations for Managed Care entities.

AHCCCS takes its responsibility as the catalyst and overseer of the Quality Strategy very seriously. The AHCCCS Administration has and will continue to collaborate with its stakeholders to optimize the health outcomes of its members.

SECTION I
QUALITY STRATEGY OVERVIEW

The AHCCCS Medicaid program began its acute care program in 1982. The AHCCCS Long Term Care System (ALTCS) was added in December of 1988 for persons with developmental disabilities and January of 1989 for the Elderly and physically disabled populations. . Additional groups were added to the acute care population in 2001, as a result of the vote of the people of Arizona (Proposition 204). As of October 1, 2005, there are 1,013,800 acute care members and 41,256 ALTCS members being served by a combined total of 13 Managed Care Organizations (MCOs) and two Prepaid Inpatient Health Plans (PIHPs) statewide. The services of the PIHPS are limited to behavioral health and Children's Rehabilitative Services. MCOs and PIHPs in the AHCCCS program are called Contractors. The AHCCCS Administration intends to increase members' health security by its emphasis on the following:

- Customer-focused Contractors as demonstrated by:
    - Choice
    - High member satisfaction, and
    - Incentive for wellness.
- Continuous improvement in quality of care
- Integrated service networks and community resources
- Effective cost management, and
- Focus on member/provider assistance and service support by:
    - Maximizing information resources
    - Increasing emphasis on disease management
    - Increasing preventive care to reduce risk, and
    - Enhancing e-health capabilities.

Mission

The Quality Assessment and Performance Improvement Strategy is founded on AHCCCS' mission of "reaching across Arizona to provide comprehensive, quality health care for those in need". Inherent in carrying out the mission is the AHCCCS Administration's commitment to drive quality through the development of the Quality Strategy. The Agency then establishes its goals, objectives and timetables for health care improvements.

Vision

AHCCCS has long been respected as an innovator in the area of Medicaid managed care. It is AHCCCS' goal to remain a leader by increasing its pro-activity in the quality arena. The Agency's vision includes:

- Advocating for customer-focused health care;
- Leading the development of new quality of care initiatives and quality improvement strategies;
- Continuing its role as an innovator of health coverage and being seen as a valued partner and collaborator in improving the health status of Arizonans;
- Elevating its role as a facilitator of collaborative health care initiatives that leverage public and private resources;
- Connecting uninsured and at-risk Arizonans to affordable health care coverage;
- Maintaining its role as a good steward of public and private health care finances;
- Increasing its role as a health information resource; and
- Providing an optimal work environment for its employees.

Implementation

AHCCCS develops and approves the Quality Strategy through the identification of specific goals and objectives (see Section II). Members, the public, and stakeholders provide input and recommendations regarding the content and direction of the Quality Strategy. The Agency maintains the ultimate authority for overseeing the Quality Strategy management and direction.

The management responsibilities for the Quality Strategy are shared by several divisions/offices within the Agency. Internal and external collaborations/partnerships may be utilized to address specific initiatives and/or issues. The AHCCCS Administration oversees the Quality Strategy's overall effectiveness and performance of its Contractors. AHCCCS is responsible for reporting Quality Strategy activities, findings, and actions to members, other stakeholders, Contractors, the Governor, legislators, and the Centers for Medicare and Medicaid Services (CMS).

SECTION II
FIVE-YEAR STRATEGIC GOALS AND OBJECTIVES

AHCCCS requires the provision of high quality health care and services whose quality can be demonstrated to its members, the community and its funders. AHCCCS has formulated evidenced-based outcomes and new quality initiatives that:

- Reward quality of care, member safety and member satisfaction outcomes;
- Support best practices in disease management and preventive health;
- Provide feedback on quality and outcome to Contractors and providers, and
- Provide comparative information to consumers.

AHCCCS has adopted the following tenets as part of its five-year goals:

- Enhance current performance measures and performance improvement projects and best practices activities by creating a comprehensive quality of care assessment and improvement plan across all AHCCCS Medicaid programs that will serve as a roadmap for driving member-centered improved outcomes. Objectives include:
    - Continuing use of nationally recognized protocols, standards of care, and benchmarks, and
    - Establishing a system of rewards for physicians, in collaboration with its Contractors, based on clinical best practices and outcomes.
- Build upon prevention efforts and health maintenance/management to improve AHCCCS members' health status through targeted medical management in the following areas:
    - Emphasizing disease management
    - Improving functionality in activities of daily living
    - Planning patient care for the special needs population
    - Increasing emphasis on preventative care,
    - Identifying and sharing best practices, and
    - Exploring Centers of Excellence
- Develop collaborative strategies and initiatives with state agencies and other external partners. Objectives include:
    - Establishing strategic partnerships to improve access to health care services and affordable health care coverage;
    - Collaborating with Contractors and providers on best practices in disease prevention and health maintenance;

  - Partnering with sister agencies, Contractors and providers to educate Arizonans on health issues;
  - Assuring the effective medical management of at risk and vulnerable populations;
  - Building capacity in rural and underserved areas, and
  - Collaborating on border health care issues.

- Enhance customer service and improve information retrieval and reporting by upgrading information and telephone technologies and thereby increasing responsiveness and productivity. Objectives include:

  - Enhancing web–based self-help and health/medical information applications;
  - Replacing the mature AHCCCS Prepaid Medical Management Information System (PMMIS) to enhance functionality, and
  - Creating a data warehouse to store data from various sources and systems to provide more robust retrieval and reporting capabilities.

- Manage AHCCCS health care cost inflation in proportion to state fund revenues.

SECTION III
QUALITY STRATEGY ELEMENTS / DESCRIPTION

The AHCCCS Administration has built its quality structure over time by means of its adherence to federal requirements, continual review of applicable national standards and national and/or regional trends, collaboration with partners, and its own experiences. The various components of the overall AHCCCS Quality Strategy are briefly described below. The Agency uses this model when considering the addition of new clinical and non-clinical projects to enhance the well-being of its members.

A. Receiving stakeholder input

The success of AHCCCS can be attributed, in part, to concerted efforts by the Agency to foster collaborative partnerships with its sister agencies, Contractors (Administrators and Medical Directors) providers (physicians, other professionals, paraprofessionals) and the community (advocacy groups, non-profit and for-profit groups). The AHCCCS Administration regularly seeks input through a variety of methods.

B. Developing and assessing the quality and appropriateness of care/services for members

The AHCCCS Administration develops measures and assesses the quality and appropriateness of care/services for its members using the following processes:

- Identifying priority areas for improvement

  The AHCCCS Administration regularly establishes key clinical and non-clinical areas on which to focus future efforts. This is done through analysis of state and national trends and in consultation with other entities working to improve the health care in Arizona such as the Medicare Quality Improvement Organization (QIO), community leaders, other state agencies, and AHCCCS Contractors.

- Establishing realistic outcome-based performance measures

  The AHCCCS Administration establishes minimum performance standards, goals, and benchmarks based on national standards whenever possible. Contractors are expected to achieve the minimum performance standard for performance measures. Performance measure reports, such as that for immunizations, may compare the Contractor results with each other and with Medicaid and commercial health plan national averages. The rationale for establishing these measures is for Contractors to develop methods to continuously increase the well-being of their respective populations through the removal of barriers to care and ongoing process improvement.

Each Contractor is expected to conduct Performance Improvement Projects (PIPs) in clinical care and non-clinical areas that are expected to have a favorable impact on health outcomes and member satisfaction. Utilizing financial, population, and disease-specific data and input from the Contractors, the AHCCCS Administration selects a focus for performance improvement to be measured across Contractors. In addition, Contractors are required to review their data and quality measures to determine Contractor-specific Performance Improvement Projects.

- Identifying, collecting and assessing relevant data

  Methods may vary given the project. Data sources can include but are not limited to computer-based information, member records, interviews and surveys. The Agency and/or its Contractors may also use an External Quality Review Organization (EQRO) to assist in some or all phases of a project.

- Providing incentives for excellence and imposing sanctions for poor performance

  Beginning in 2003, the AHCCCS Administration began posting aggregate results of performance measures on the AHCCCS website. Web site posting has been expanded to include contractor's individual performance measure rates. It is expected that the posting will be viewed as an incentive by Contractors to improve their performance rates. The AHCCCS Administration will continue to explore creative ways to provide incentives for performance improvement and positive outcomes.

  Corrective action plans are required from Contractors not achieving minimum performance standards. This approach has resulted in a positive trend overall in performance measure rates and a positive impact for AHCCCS members. The AHCCCS Administration provides various incentives, technical assistance, and may impose sanctions if improvement is not achieved. An example of an incentive is the increase in the auto-assignment algorithm for Contractors who demonstrate improved quality of care in two specific performance measures.

- Sharing best practices

  The AHCCCS Administration regularly shares best practices and provides technical assistance with its Contractors. In addition, Contractors are encouraged to share evidence-based best practices with each other and their providers. An example of this is the sharing of successful interventions during AHCCCS Contractor quality management meetings.

C. Including medical quality assessment and performance improvement requirements in the AHCCCS contracts

The AHCCCS Administration includes all federally required elements in the contracts and monitors them accordingly.

D. Regular monitoring and evaluating of Contractor compliance and performance

The AHCCCS Administration monitors and evaluates access to care, organizational structure and operations, clinical and non-clinical quality measurement and performance improvement outcomes through:

- Annual on-site Operational and Financial Reviews;
- Review and analysis of periodic reports, and
- Review and analysis of program-specific Performance Measures and Performance Improvement Projects.

Appropriate action is taken depending on the results.

E. Maintaining an Information System that supports initial and ongoing operations and review of the established Quality Strategy

The AHCCCS Administration uses a statewide, automated managed care data system to support the processing, reporting, research and project needs of the Agency and its Contractors.

The AHCCCS Administration performs extensive data validation. Known as encounter data, these records of services provided are submitted to the Agency for all Medicaid covered services including institutional, professional, dental, and medication/pharmacy services, with each having its own format. The AHCCCS Administration also performs annual validation studies on Contractor data to ensure that the data has been reported timely, is accurate and complete.

F. Reviewing, revising and beginning new projects in any given area of the Quality Strategy

Review and revision of the components of the Quality Strategy is an ongoing process for AHCCCS. New projects and/or strategies may evolve from current ones. Success with improvements and outcomes are monitored over time for sustainability prior to retiring the project. The process repeats itself for the development of new studies followed by interventions to improve the health and well-being of AHCCCS members.

G. Reviewing the Quality Strategy Document

In an effort to maintain a commitment to continuous improvement, the Quality Strategy document will be reviewed annually and/or when a significant change occurs. Changes in Agency documents such as policy manuals and contracts will be made as appropriate. A significant change is defined as any change to the Quality Strategy that may reasonably be foreseen to materially affect the delivery or measurement of the quality of health care services.

SECTION IV
QUALITY STRATEGY SCOPE

As stated earlier, AHCCCS's Contractors currently serve over 1 million Medicaid managed care members statewide.

The following are encompassed within the scope of the Quality Strategy:

- Medicaid Managed Care members in the acute, long-term care, Children's Rehabilitative Services and behavioral health programs.

- Aspects of care including: coordination, accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services covered by AHCCCS.

- Aspects of Contractor performance relating to access to care, quality of care and service including, but not limited to: disease management, preventative care, health promotion, patient care planning, network contracting and credentialing, and grievance systems.

- Medically necessary covered services such as inpatient hospital services, outpatient services, other laboratory and x-ray services, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, behavioral health services, physician services, home health services and emergency services.

- Professional and institutional care in any setting, including inpatient and outpatient, in-home, and alternative settings.

- Providers and any other delegated or subcontracted provider type such as providers of transportation and durable medical equipment.

- Aspects of the Contractors' internal administrative processes that are related to service and quality of care. This includes member services, provider relations, confidential handling of medical records and information, case management services, utilization review activities, preventive health services, health education, information systems and quality improvement.

SECTION V
QUALITY STRATEGY AND COMPLIANCE WITH THE BALANCED BUDGET ACT (BBA) REQUIREMENTS

In 1997, the BBA mandated that States ensure the delivery of quality health care by all their Managed Care Contractors. CMS finalized the regulations (42 CFR 438 et. seq.) for the Act and published it on June 14, 2002. The regulations set forth specifications for quality assessment and performance improvement strategies that the State must develop, if not already in place. The AHCCCS Administration has had a formal Quality Initiative and Performance Improvement Plan since 1994. AHCCCS has spent the past year analyzing, planning, and implementing any requirements that were not already in place. The BBA regulations also establish standards that the AHCCCS Administration and its Contractors must meet.

AHCCCS Responsibilities

The Quality Strategy includes the following responsibilities as outlined in the regulations. AHCCCS must:

- Have a strategy for assessing and improving the quality of managed care services offered by all Contractors;
- Document the strategy in writing;
- Provide for the input of members and stakeholders in the development of the strategy, including making the strategy available for public comment before adopting it as final;
- Ensure compliance with standards established by AHCCCS, consistent with the regulations;
- Conduct periodic reviews to evaluate the effectiveness of the strategy, and update the strategy as often as AHCCCS considers appropriate;
- Provide to CMS a copy of the initial strategy, and a copy of the revised strategy, whenever significant changes are made; and
- Provide to CMS regular reports on the implementation and effectiveness of the strategy.

Key BBA Requirements

The following are the key areas which the BBA regulations have designated as requirements in the Agency's overall Quality Strategy. The subject of each segment has been identified followed by the federal citation as reference.

A. State process for Quality Strategy development, review and revision (public involvement included) (42 CFR 438.202)

The AHCCCS Administration has long been respected as an innovator in the area of Medicaid managed care. It is our commitment to quality and a desire to continue that history of innovation and continuous improvement that has helped Arizona remain in the forefront.

The development of the Quality Strategy and review of existing AHCCCS quality measures followed a three-pronged approach. Using a workgroup process, the AHCCCS Administration first engaged in a review of the current components of the Agency's quality initiative, cataloging the various processes in place to develop, review and revise quality measures. Second, a review was completed of AHCCCS materials that illustrate the focus on quality, which is central to the Agency's mission and vision. Finally, the Quality Strategy document was developed to include the overall strategic goals and objectives related to quality, the quality-improvement approach of the Agency, and the quality measurement initiatives and overview processes.

The Quality Strategy is applicable to AHCCCS acute and long-term care Contractors, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) and the ADHS Children's Rehabilitative Services (CRS). It is also applicable to the Agency's internal processes involving enrollee information, monitoring and evaluation.

In part, the success of AHCCCS can be attributed to concerted efforts by the Agency to foster collaborative partnerships with its Contractors, sister agencies, providers and the community. The Agency regularly seeks input through a variety of methods such as public forums, member councils, and meetings with its Contractors and providers. In order to provide for public involvement and comment on changes resulting from the BBA regulations, the AHCCCS Administration includes the Contractors in discussions regarding strategies and implementation of the BBA regulations.

For the original document, as well as any subsequent substantive changes, the Agency solicits input from the Director's State Medicaid Advisory Committee (SMAC) whose composition includes the Director of AHCCCS; representation from the Native American community; Medicaid members; senior, disabled, and child advocacy communities; nursing facility and home and community based advocates; the medical community (physician); Arizona Department of Health Services (ADHS); and the Arizona Department of Economic Security (ADES). The SMAC meeting is an open meeting and is regularly attended by citizens, in addition to the council members.

B. State verification that Sub-Part D provisions of the BBA regulations are included in Medicaid contract provisions [42 CFR 438.204(a)]

The AHCCCS Administration incorporates in its MCO (Health Plans & Program Contractors) and PIHP (ADHS/DBHS & CRS) contracts the Sub-Part D provisions, which include standards for:

- Access to care (availability and adequate capacity of services, coordination and continuity of care, and coverage and authorization of services),
- Structure and operations (provider selection, confidentiality, and grievance system), and
- Quality measurement and improvement provisions (practice guidelines, quality assessment, performance improvement and health information systems).

Through its collaboration with the Centers for Medicare and Medicaid Services (CMS), the AHCCCS Administration maintains a "checklist for managed care contract approval". This checklist provides, in detail, an explanation of the standard and where it can be found in the contract.

C. State assessment of quality and appropriateness of care/services for routine and special health care needs members [42 CFR 438.204(b)(1) & 438.208(c)(1)(i)]

The AHCCCS Administration monitors quality and appropriateness of care/services for routine and special health care needs members through annual Operational & Financial Reviews of Contractors and the review of required Contractor deliverables set forth in contract, program specific performance measures, and performance improvement projects. The Agency has had established performance standards and a system for monitoring and evaluating with regard to performance measures and improvement projects since 1994. The following are examples of activities in each of the assessment areas.

- Operational and Financial Reviews (OFR)

  During annual on-site reviews, the AHCCCS Administration conducts a review of each Contractor's compliance related to:

  - Development and implementation of policies,
  - Performance related to quality measures,
  - Progress toward applicable plans of correction in place to improve quality of care, and
  - Service outcomes for members.

- Contractor Periodic Reporting Requirements (Deliverables)

  Required contract deliverables include, but are not limited to:

  - Quality Management/Utilization Management Plan and Evaluation (annually, Contractors must submit a comprehensive plan explaining strategies for maintaining quality of care for members as well as a progress report on ongoing strategies);
  - Provider Network Development and Management Plan (to ensure that there are adequate types and numbers of providers in any given area);
  - EPSDT (for children up to the age of 21) and oral health plan;
  - Annual Maternity Plan;
  - Quarterly quality management reports;
  - Quarterly utilization management reports, and
  - Quarterly progress updates as required.

  The AHCCCS Administration reviews, provides feedback, and approves the various plans as appropriate.

- Performance measures

  The Agency uses the Health Plan Employer Data and Information Set (HEDIS®) as a guideline for its methodology to develop, collect and report data for most Performance measures. The results reported are indicators of members' use of services, rather than absolute rates for how successfully the AHCCCS Administration and/or its Contractors provide care. The measures provide trend information, which may provide guidance in designing focused interventions for quality improvement by AHCCCS Contractors. If minimum performance standards (MPS) are not achieved, Contractors are required to develop and submit corrective action plans with interventions that will assist them in meeting MPS. Examples include: measures for adolescent well-care visits, home- and community-based (HCB) services, timely initiation of services including prenatal care, and coordination of care between behavioral health professionals and acute care primary care providers.

  The AHCCCS Administration utilizes several methods to encourage improvements in performance measure rates. Beginning in 2003, the Agency began posting aggregate results of performance measures on the AHCCCS website. Website postings will include Contractor's individual performance measure rates. It is expected that the posting will be viewed as an incentive by Contractors to improve their rates. The AHCCCS Administration also utilizes corrective action plans to improve rates when MPS are not met. Contractors not meeting MPS for a specific performance measure must develop and implement interventions focused on improving the rate at which members receive recommended services. This approach has resulted in a positive trend overall in

performance measure rates. The AHCCCS Administration may also change the auto-assignment algorithm at any time during the term of the contract in response to Contractor specific issues.

- Performance Improvement Projects

The AHCCCS Administration considers a Performance Improvement Project (PIP) as a planned process of data gathering, evaluation, and analysis to determine interventions or activities that are anticipated to have a positive outcome. PIPs are designed to improve the quality of care and service delivery and include:

- Identifying areas for improvement;
- Gathering baseline data from administrative data and other sources;
- Designing and implementing interventions;
- Measuring the impact of the intervention, and
- Maintaining/sustaining that improvement.

The Agency may require its Contractors to submit a PIP proposal with its Quality Management Plan. Contractors are also required to submit annual PIP milestone reports as well as final reports. The improvement strategy must include, at a minimum, identification of the team that will address the problem, a root cause analysis, identification of interventions that will be implemented, and a proposed timeline.

Examples of PIPs currently underway by AHCCCS Contractors include follow-up services provided after discharge from an inpatient setting and assessment of appropriate use of medications for members diagnosed with asthma.

The timeframes adhered to by the AHCCCS Administration are as follows:

- First year, the baseline numbers are submitted;
- Second year is the intervention year (no report is due);
- Third year is a re-measurement that will show if performance improved since baseline; and
- Fourth year is another re-measurement to measure sustainability of efforts.

The Agency and/or the Contractors will re-measure for at least two years to achieve the BBA required "sustained improvement." If a Contractor's performance improves as a result of interventions, the PIP will be a minimum of four years in duration.

The AHCCCS Administration also mandates a number of Agency-specified PIPs. Contractors are required to participate, and these may vary by contract type. For example, the required PIP for acute care Contractors may not be the same as for long-term care Contractors. An example of a mandated PIP is the Diabetes Improvement Project that seeks to enhance preventive care and improve the

outcomes in the management and treatment of AHCCCS members diagnosed with diabetes.

Note: Members with special health care needs definition

Members with special health care needs are those members who have serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally. A member will be considered as having special health care needs if the medical condition simultaneously meets the following criteria:

- Lasts or is expected to last one year or longer, and
- Requires ongoing care not generally provided by a primary care provider.

AHCCCS has determined that the following populations meet this definition:

- Acute care:
  - Members who are recipients of services provided through the Arizona Department of Health Services Children's Rehabilitative Services (CRS) program;
  - Members who are recipients of services provided through the Arizona Department of Health Services Division of Behavioral Health contracted Regional Behavioral Health Authorities (RBHAs), and
  - Members diagnosed with HIV/AIDS.

- Arizona Long-Term Care System (ALTCS):
  - Members enrolled in the ALTCS program who are elderly and/or physically disabled, and
  - Members enrolled in the ALTCS program who are developmentally disabled.

Contractors may also choose to identify as members with special health care needs any other members who they determine meet the definition.

D. State procedures for identifying race, ethnicity, and primary language of each member [42 CFR 438.204(b)(2)]

The AHCCCS Administration receives the member's race, ethnicity, and primary language information from the eligibility source, which collects this information at the time of application.

This information is systematically updated on the AHCCCS member record file and transmitted daily to the Contractor on the member enrollment roster. Changes to this information are also updated and transmitted to the Contractor.

The Contractor communicates to the Agency any member information collected by the Contractor that is different from what was provided to them. The AHCCCS Administration updates the member information as appropriate.

This information is included on the data exchange file received from the Social Security Administration. If the information is missing, the system will default to unknown or unspecified. See the previous paragraph for discussion of the information communicated from the Contractor. The AHCCCS Administration continues to evaluate this area and establishes other procedures if necessary.

The AHCCCS Administration has identified seven ethnicity categories as follows:

- Asian/Pacific Islander
- Black
- Cuban/Haitian
- Caucasian/White
- Hispanic
- Native American
- Unknown/Unspecified

If the member does not provide or does not wish to provide this information, he will be designated unknown/unspecified.

Currently there are codes for 80 languages that can be captured electronically. The AHCCCS Administration periodically assesses the language data to determine the need to expand the prevalent language categories. To date, the prevalent languages in the AHCCCS population are English and Spanish.

E. Regular state monitoring and evaluation of MCO and PIHP compliance [42 CFR 438.204(b)(3) & 438.416]

The AHCCCS Administration monitors and evaluates Contractor compliance through annual Operational and Financial Reviews (OFR), through the review and analysis of periodic reports as required in the contract, program specific Performance Measures, and Performance Improvement Projects. In addition to the information provided in Section V, Segment C, the following is a description of the broad spectrum of the OFR. In order to ensure a Contractor's operational and financial program compliance with its contract with the AHCCCS Administration, the AHCCCS review team:

- Determines if the Contractor satisfactorily meets AHCCCS requirements as specified in contract, policy and rule;
- Reviews the progress made toward implementing the recommendations made during the previous review;
- Reviews outcomes of interventions for Performance Measures and Performance Improvement Projects;
- Reviews records of appeals for timeliness and appropriateness;
- Determines if the Contractor is in compliance with its policies and procedures, and evaluates the effectiveness of those policies and procedures;
- Provides technical assistance and identifies areas in which improvements can be made, as well as identifying areas of noteworthy performance and accomplishment;
- Conducts interviews or group conferences with members of the Contractor's administrative staff; and
- Examines records, books, reports, and information systems of the Contractor, or any management company as necessary.

As a condition of its 1115 Waiver, the AHCCCS Administration performs extensive data validation. Known as encounter data, these records of services provided are submitted to the Agency for all Medicaid covered services including institutional, professional, dental, and medication/pharmacy services, with each having its own format. The AHCCCS Administration also performs annual validation studies on Contractor data to ensure that the data has been reported timely, is accurate, and complete. Since sanctions may be imposed on the Contractor, based on the results of the data validation studies, the Agency provides technical assistance and training to the Contractors to support the Contractor's ability to meet the AHCCCS Administration requirements. OFR and data validation results are reported to CMS in accordance with the 1115 Waiver Terms and Conditions.

F. National performance measures and levels [42 CFR 438.204(c)]

National performance measures and levels have not officially begun; however much progress has been made toward this goal. The Centers for Medicare and Medicaid Services (CMS) contracted with the National Academy for State Health Policy (NASHP) to identify opportunities and issues in the development and use of performance measurements in Medicaid and State Children's Health Insurance Programs (SCHIP). Arizona was one of 15 states asked to participate in this nation-wide project, which initially met in Washington, DC on March 18-19, 2002.

A distilled list of core performance measures have been identified, discussed and agreed upon by the participants. These initial seven core performance measures are:

- Well child visits for children less than 15 months;
- Well child visits in the 3rd, 4th, 5th, and 6th years of life;
- Use of appropriate medications for children with asthma;
- Diabetes care (adult measure only);
- Children's access to primary care providers;
- Adult access to preventive/ambulatory health services; and
- Initiation of prenatal care

There was agreement that other new core measures would need to be introduced or phased-in over time. Some areas that were identified as potential topics that would need to be added into the next round of measures included behavioral health and adolescent access to care.

G. Arrangement for annual external performance review [42 CFR 438.204(d)]

The Agency conducts most of the components of the Quality Strategy in-house. There are a limited number of Performance Improvement Projects and performance measurement processes conducted directly by an External Quality Review Organization (EQRO). For purposes of BBA compliance, AHCCCS contracts with three different EQROs. The EQROs review the quality monitoring activities of AHCCCS and write an independent report on each AHCCCS Contractor. The reports include areas of strength, and areas requiring improvement by the Contractor.

H. For MCOs, intermediate sanctions that meet the requirements of Sub-Part I [42 CFR 438.204(e)]

The AHCCCS Administration may impose monetary sanctions, suspend, deny, refuse to renew, or terminate a contract or any related subcontracts in accordance with AHCCCS Rules R9-22-606 and the terms of the contract and applicable Federal or State law and regulations. Written notice will be provided to the Contractor specifying the sanction to be imposed, the grounds for such sanction, and either the length of suspension or the amount of capitation prepayment to be withheld. The Contractor may appeal the decision to impose a sanction in accordance with 9 A.A.C. 34. Intermediate sanctions may be imposed, but are not limited to the following actions:

- Substantial failure to provide medically necessary services that the Contractor is required to provide under the terms of this contract to its enrolled members;
- Imposition of premiums or charges in excess of the amount allowed under the AHCCCS 1115 Waiver;
- Discrimination among members on the basis of their health status or need for health care services;
- Misrepresentation or falsification of information furnished to CMS or AHCCCSA;
- Misrepresentation or falsification of information furnished to an enrollee, potential enrollee, or provider;
- Failure to comply with the requirement for physician incentive plan as delineated in contract;
- Distribution directly, or indirectly, through any agent or independent contractor, of marketing materials that have not been approved by AHCCCSA or that contain false or materially misleading information;
- Failure to meet AHCCCS Financial Viability Standards;
- Material deficiencies in the Contractor's provider network;
- Failure to meet quality of care and quality management requirements;
- Failure to meet AHCCCS encounter standards;
- Violation of other applicable state or federal laws or regulations;
- Failure to fund accumulated deficit in a timely manner;
- Failure to increase the Performance Bond in a timely manner; and
- Failure to comply with any provisions contained in the contract.

The AHCCCS Administration may impose the following types of intermediate sanctions:

- Civil monetary penalties;
- Appointment of temporary management for a Contractor as provided in 42 CFR 438.706 and A.R.S. §36-2903;

- Allowing members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll;

- Suspension of all new enrollment, including auto assignments, after the effective date of the sanction;

- Suspension of payment for recipients enrolled after the effective date of the sanction until CMS or AHCCCSA is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur; and

- Additional sanctions allowed under statute or regulation that address areas of noncompliance.

Cure Notice Process:

Prior to the imposition of a sanction for non-compliance, the AHCCCS Administration may provide a written cure notice to the Contractor regarding the details of the non-compliance. The cure notice will specify the period of time during which the Contractor must bring its performance back into compliance with contract requirements. If, at the end of the specified time period, the Contractor has complied with the cure notice requirements, the Agency ~~will~~ **MAY** take no further action. If, however, the Contractor has not complied with the cure notice requirements, the AHCCCS Administration will proceed with the imposition of sanctions.

The AHCCCS Administration has a sanctions policy that details for the Contractors the requirements cited in 42 CFR 438, Subpart I. The policy cites the types of sanctions and subsequent monetary penalties or other types of sanctions, should a Contractor not adhere to the provisions of the Medicaid Managed Care program or contractual requirements.

I. Information system that supports initial and ongoing operations and review of established quality strategy [42 CFR 438.204(f)]

The AHCCCS Administration has mechanisms in place to ensure that its Contractors maintain information systems that collect, analyze, integrate and report data, and can achieve the objectives of the AHCCCS program. Contractors are required to have available claims processing and management information sufficient to support provider payments and data reporting between themselves and AHCCCS. Contractors must also collect service-specific procedures and diagnosis data, encounters, and maintain detailed records of remittances to providers. The AHCCCS Administration assesses data accuracy and completeness.

The AHCCCS Administration uses a statewide, automated managed care data system to satisfy the processing and reporting needs of the MCOs and PIHPs. The system is known as the Prepaid Medical Management Information System (PMMIS). It is composed of eleven core subsystems, five reporting and quality oversight subsystems,

and a security subsystem. PMMIS provides extensive information, retrieval, and reporting capabilities to satisfy the data needs of the Agency, CMS, other state and federal agencies, counties, Contractors, providers and members. The system processes Contractor encounters for all AHCCCS members as well as supports the monitoring of service utilization, quality of care, and program expenditures. PMMIS is a mature system that has been modified over time to accommodate the growing and changing needs of the AHCCCS program.

J. State standards at least as stringent as those in Sub-part D for: access to care, structure and operations, and quality measurement and improvement [42 CFR 438.204(g)]

The contracts between the AHCCCS Administration and its MCOs and PIHPs set forth the standards for access, structure and operations, and quality measurement and improvement. Section D of the acute care contract is attached as an example. The AHCCCS Medical Policy Manual (AMPM), as well as other AHCCCS policies and manuals, are incorporated by reference as part of the MCO/PIHP contracts and provide more detailed information and requirements.

K. Enrollee Information (42 CFR 438.218 & 438.10)

42 CFR 438.10 sets forth the requirements for both the AHCCCS Administration and its Contractors regarding the types and distribution of enrollee information.

- AHCCCS Administration Processes

  In addition to the information in Section V, Segment D of this text, the AHCCCS Division of Member Services (DMS) has:

  - Revised the application for AHCCCS Health Insurance (AHI) to include all the BBA requirements concerning potential enrollees. For those situations where an application other than the AHI application is used, DMS has developed a stand-alone document to use with these applications. This document includes all of the BBA and pre-enrollment requirements, and is given or mailed to all applicants at the time of their application. A copy of this document is attached.

  - Assured eligibility staff have access to the provider listing by Contractor for their geographic service area (GSA) and will share this with the applicant.

  - Translated vital documents into Spanish, currently the only other prevalent language in Arizona. Bilingual staff are hired in key areas and the AHCCCS Administration has a contract with *Language Line Services* to facilitate oral interpretation for other languages. Applicants are provided with other methods of communication if special accommodations are needed, such as special accommodations for visually and/or hearing-impaired members.

The AHCCCS administration also provides links to the AHCCCS Contractors' Web sites. This enables applicants to view the contractor networks from the AHCCCS Web site.

- MCO / PIHP Processes

  AHCCCS MCOs and PIHPs are required as specified in contract, Section D and Attachment H, as well as in the AHCCCS member information policy, to provide members with information including, but not limited to, the following: covered services, how to obtain services, how to choose a provider, their rights with respect to grievances and state fair hearings, prior authorization, advance directives, what constitutes an emergency, language and cultural competency requirements, and the member's financial responsibilities. The AHCCCS Administration monitors these areas by means of the OFR described in Section V, Segment E of this text.

CONCLUSION

AHCCCSA is committed to increasing its pro-active role as a "quality of care improver", while maintaining its traditional role as the monitor of quality of care. The Agency's process for moving forward is assessing where the program stands today, stating the goals it intends to accomplish, and developing detailed plans to serve as a roadmap.

AHCCCSA has developed an extensive "Strategic Plan for Disease Prevention and Health Maintenance" based on the five-year strategic goals and objectives described in Section II. The implementation of the plan will result in better health and well-being for AHCCCS members. The following are examples of expected outcomes:

- Improved performance by Contractors as a result of incentives such as comparative reporting and financial advantages;

- Informed members, who understand the value of preventative care; and for those members with chronic diseases, the ability to maintain or increase their health;

- A physician community that is increasingly vested in the prevention of disease;

- Systematic research and sharing of best practices and lessons learned both locally and nationally;

- A significant reduction in the costs associated with treating disease and adverse health outcomes; and

- Broader participation in collaborative community efforts to improve the health status of Arizonans.

AHCCCS is currently the largest health care insurer in the state of Arizona. As such, it has a unique opportunity to utilize its experience, expertise and commitment to achieve continued success as a steward of quality health care in Arizona. AHCCCS looks forward to meeting this challenge.